The Prudential Insurance Company of America

Evidence of Insurability

Instructions for Employer/Association

1. Complete the form below.

2. Also complete all sections of the form noted "PART A" including product related information as applicable to the plan(s) requiring medical evidence of insurability.

3. The entire package should then be given to your employee or member for completion of Part B.

In the space below, insert mailing address to which the notice of action should be sent.

Submitting Location: _____

Employer/Association Name & Address:

_____

_____

_____

Group Contract No. _____ Branch No._____

Signed for Employer/Association by:

_____
Name

_____
Title

_____
Telephone Number

_____
Date

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Part A Employer/Association Information

Complete this page as applicable to the plan(s) requiring evidence of insurability, then give this package to the employee/member.

Employee/Member First Name _____ MI _____ Last Name _____

Date of Birth _____ Social Security Number _____–_____–_____ Sex ☐ Male ☐ Female

Street _____ Apt. _____

City _____ State _____ ZIP code _____–_____

Date individual first became eligible for coverage(s)/amount(s) of insurance this form applies to: _____

Employee/Member Annual Earnings: $_____

Is application being made for amounts above the Life non-medical maximum? Yes ☐ No ☐

Is application being made as a late entrant? Yes ☐ No ☐

Is application being made for dependents? Yes ☐ No ☐

Life/AD&D

Total Non-Medical Maximum $_____

	Current Amount Inforce	+	Addt'l or Initial Amount Requested	=	Total Amount
Employee/Member	$_____	+	$_____	=	$_____
Spouse (Life only)	$_____	+	$_____	=	$_____
Child (Life only)	$_____	+	$_____	=	$_____

Long Term Disability

	Current Amount Inforce	+	Addt'l or Initial Amount Requested	=	Total Amount
Employee/Member	$_____	+	$_____/mo	=	$_____

Survivor Benefits Life

	Current Amount Inforce	+	Addt'l or Initial Amount Requested	=	Total Amount
Spouse	$_____/mo	+	$_____/mo	=	$_____
Child	$_____/mo	+	$_____/mo	=	$_____

Weekly Disability Income/Accident & Sickness Benefit

Amount $_____

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Instructions for Employee/Member (Complete the Required Sections as Noted Below.)

1. If you are providing evidence of insurability for:
   a) Employee/Member Coverage only – Complete Sections 1, 2, 4 and 5.
   b) Dependent Spouse/Child(ren) only – Complete Sections 1, 3, 4 and 5.
   c) Employee/Member and Dependent Spouse/Child(ren) – Complete All Sections of this form.

2. Please read and tear off the Important Medical Information Notice that accompanies these instructions and retain for your records. Also, please retain a copy of your completed application for your own records.

3. Mail the completed PART A and PART B forms to:

Mailstop NJ-11-01-01
The Prudential Insurance Company of America
Group Medical Underwriting
290 West Mt. Pleasant Ave.
Livingston, NJ 07039-2729

The evaluation of your request for coverage may be delayed if you do not follow these instructions, if you and/or your dependents do not answer all questions on the PART B form, or if you do not give complete details for any answers requiring details or do not provide complete names and addresses of doctors and hospitals.

NOTE: Coverage is not effective until this request has been approved. You will be contacted whether or not coverage has been approved.

If you have questions regarding the completion of these forms, please contact Prudential Customer Service at 1-888-257-0412.

Part B Employee/Member Information

Section 1

1. Employee/Member First Name | MI | Last Name

2. Employee/Member Social Security Number ___ – ___ – ___

3. Employee/Member Phone Number
   Daytime ___ ___ – ___
   Evening ___ ___ – ___

4. Street | Apt.

City | State | ZIP code ___ – ___

Section 2

5. Date of Birth
   ___ ___ ___
   month day year

6. Birth Place
   ___ ___
   city state

7. Sex
   ☐ Male ☐ Female

8. Height
   ___ ft. ___ in.

9. Weight
   ___ lbs.

Section 2 (continued)

10. Name and address of current doctor:

Physician First name | MI | Last name

Street | Suite

City | State | ZIP code

11. Are you currently able to perform all the duties of your job? ☐ Yes ☐ No
If "No", provide full details in item 16.

12. Have you **during the last five years:**

a. had any surgery, or been advised to have surgery and have not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? Yes ☐ No ☐
c. used, or are you now using, cocaine, barbiturates or amphetamines, marijuana or other hallucinatory drugs, or heroin, opiates or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
d. been treated or counseled for alcoholism? Yes ☐ No ☐
e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
g. had life, disability or health insurance declined, postponed, changed, rated-up, cancelled or withdrawn? Yes ☐ No ☐
h. been diagnosed as having or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

13. **Within the last five years**, have you been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

14. Do you **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above and/or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

15. Have you smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used nicotine gum within the past year? If "Yes", which product? _____ Yes ☐ No ☐

16. What are the full details of all "Yes" answers to each part of 12 through 14? Attach additional pages if needed.

Question No. and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment and/or medication	Date illness or condition began *Month Year*	Time lost from normal activities	Full recovery (if applicable) *Month Year*	Print full names, addresses & telephone numbers of doctors and/or hospitals

Section 3

1. Employee/Member's eligible dependents that are applying for coverage.

Full Name	Social Security Number	Relationship to You	Date of Birth	Place of Birth	Height	Weight

2. Address of your dependents (if different from address in Section 1):

3. Are any of the above dependents who are age 19 and older full-time students?
If so, please state the college or institution: Yes ☐ No ☐

4. Are any of the persons named above unable to perform all of the duties of their job, or home-confined? Yes ☐ No ☐

5. Have any of the persons named above **during the last five years**:

a. had any surgery, or been advised to have surgery and have not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? Yes ☐ No ☐
c. used, or are they now using, cocaine, barbiturates or amphetamines, marijuana or other hallucinatory drugs, or heroin, opiates or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
d. been treated or counseled for alcoholism? Yes ☐ No ☐
e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
g. had life, disability or health insurance declined, postponed, changed, rated-up, cancelled or withdrawn? Yes ☐ No ☐
h. been diagnosed as having or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

6. **Within the last five years**, have any of the persons named above been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

7. Do any of the persons named above **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above and/or are they currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

8. What are the full details of all "Yes" answers to each part of 4 through 7 above? Attach additional pages if needed.

Dependent's Name	Question No. and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment and/or medication	Date illness or condition began *Month Year*	Time lost from normal activities	Full recovery (if applicable) *Month Year*	Print full names, addresses & telephone numbers of doctors and/or hospitals

Section 4

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, and the District of Columbia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee and the District of Columbia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding $5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who, with the intent to defraud or knowing that the person is facilitating a fraud against an insurer, submits a false or deceptive statement may have violated the state law.

In Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may subject such person to criminal and civil penalties.

In Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Signature of Employee/Member

Date

Section 5 — AUTHORIZATION For the Release of Information

To: (1) Any licensed physician, medical practitioner, hospital, clinic or other medically related facility, (2) any insurance company, health maintenance organization (or similar type organization or institution), and (3) the Medical Information Bureau. So that eligibility for life or disability coverage can be determined, I authorize you to give any data or records you may have about me or my mental or physical health to The Prudential Insurance Company of America and/or its subsidiaries and, through it, to its reinsurers, authorized agents, and the Medical Information Bureau. This also applies to any dependent proposed for coverage in the application. This authorization is valid for the lesser of (1) two years after the effective date of any coverage issued in connection with it or (2) 30 months after the date it is signed. A photo of this form will be as valid as the original. The person(s) who signed this form (1) have received a copy of the "Medical Information Notice" and (2) may have a copy of this authorization if they wish.

Signature of Employee/Member	Employee/Member Social Security No.	Date
Signature of spouse (if to be covered)	Signature(s) of children age 14 or older (if to be covered)	Date
		Date

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau, a non-profit membership organization of Life Insurance Companies, which operates an information exchange on behalf of its members. When you apply for Life, Disability or Health Insurance to any company, including Prudential, which is a member of the Medical Information Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may also reveal this information, as necessary, to a doctor, if we find a serious health problem which you do not know about, and persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instructions on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Medical Information Bureau and you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Telephone Number (617) 426-3660.

It Is Required That You Be Given This Notice.
Please Read It Carefully, And Keep It For Your Records.